STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 100040-001**

v

Blue Cross Blue Shield of Michigan
Respondent
_____/

Issued and entered
this 28th day of October 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On September 5, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of the Office of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it on September 12, 2008.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on September 22, 2008.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM *Individual Care Blue, a PPO health care benefit certificate* (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioner fractured the little finger on his right hand in the morning of January 27, 2008. He went to the emergency room of the XXXXX hospital in XXXXX in the evening of that day. The finger was x-rayed and placed in a metal brace.

XXXXX, a BCBSM participating PPO panel provider, charged $1,789.00 for this care. BCBSM approved $1,097.14 for the care and, after applying a 30% copayment, paid $768.01 to XXXXX, leaving the Petitioner responsible for $329.13.

The Petitioner appealed the processing of the claim for the emergency room care he received at XXXXX. BCBSM held a managerial-level conference on August 19, 2008, and at the conclusion of the internal grievance process issued a final adverse determination dated August 27, 2008.

III
ISSUE

Did BCBSM properly process the claims for the Petitioner's care on January 27, 2008, at XXXXX?

IV
ANALYSIS

Petitioner's Argument

The Petitioner says that he went to the emergency room with a broken right "pinky" finger. The finger was x-rayed, which took about five minutes, and a doctor gave him a metal brace to use, which took another five minutes. The Petitioner said the physician's assistant that treated him indicated there was little they could do since it was a minor fracture and it would heal on its own. He estimates that he spent no more than 15 minutes being treated.

The Petitioner objects to the fact that BCBSM approved $1,097.14 for the very brief and minimal treatment he received for his broken finger. He thinks that BCBSM's payment alone of $768.01 is sufficient for such a minor injury and he does not think he should have to pay the

$329.13 copayment. He believes way too much has been charged for the care he received.

BCBSM's Argument

BCBSM notes that in "*Section 2: What You Must Pay,"* the certificate says (page 2.1):

> You are required to pay 30 percent of the approved amount for the covered services provided by panel providers, except:
>
> - Hospice care services
> - Specified organ transplants
> - Presurgical consultations
> - Prescription drugs

The certificate clearly provides that the Petitioner is required to pay 30% of the approved amount for covered services provided by panel providers. The approved amount is based on the procedures reported, which in this case included an x-ray and procedure code 26750 ("closed treatment distal phalangeal fracture, finger or thumb; without manipulation"). Since XXXXX is a panel provider, BCBSM says it correctly applied the 30% copayment to the $1,097.14 approved amount for the Petitioner's care and the Petitioner is responsible for paying the 30% copayment, or $329.13, to the provider.

BCBSM further said that at the managerial conference the Petitioner did not question the 30% copayment but the fact that XXXXX charged so much for relatively minor care, and indicated that the amount already paid by BCBSM should have been enough to cover the services he received.

Commissioner's Review

BCBSM's approved amount for a covered service is the lower of the billed charge or its maximum payment level for that service. BCBSM approved approximately $829.00 for the hospital facility charge, $187.00 for the surgical care, and $82.00 for the physician's service for the treatment the Petitioner received on January 27, 2008, for his broken finger.

As BCBSM acknowledged, the charge for care in a hospital is much greater than that for treatment in another setting, such as a physician's office or an urgent care facility. The charges

reflect the time, personnel, and equipment that are required in a hospital emergency room. Given that the injury was minor, as even the Petitioner recognized, it is surprising that the Petitioner felt he needed to go to the emergency room. Nevertheless, BCBSM paid its share of the approved amount for the emergency room care and did not dispute its necessity. Since XXXXX is participating, it was required to accept BCBSM's approved amount as payment in full.

The certificate is clear: the Petitioner is responsible for a 30% copayment for care provided by panel providers such as XXXXX. Therefore, the Commissioner concludes that BCBSM was in compliance with the certificate when it applied the $329.13 copayment to the Petitioner's care for his broken finger.

V
ORDER

BCBSM's final adverse determination of August 27, 2008, is upheld.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.